

PATIENT

INSURED PARTY

Last Name _____

Last Name _____

First Name _____

First Name _____

FIT Box _____

FIT Box _____

Address _____

Address _____

City _____

City _____

State _____ ZIP _____

State _____ ZIP _____

Home Phone _____

Home Phone _____

Student I.D. No. _____

Student I.D. No. _____

Employer _____

Employer _____

Work Phone _____

Work Phone _____

Date of Birth _____

Date of Birth _____

In Case of Emergency Contact _____

Phone _____

Primary Care Physician _____

Insurance Information: Please submit Insurance Cards for Copying

Consent for Treatment: The undersigned authorizes the above named Health Care Provider to provide treatment including x-rays, blood withdrawal, local anesthesia, intravenous solutions and the performance of which the Provider considers necessary and proper in the treatment of the above named patient.

Release of Records: I hereby authorize the Provider to furnish insurance companies with any information concerning my treatment that may be requested, including photocopies from my patient records as necessary for completion of my claim or as may be requested by law. I further authorize the Provider to furnish information from my records pertaining to the treatment as requested by other Doctors or medical care facilities for continued care and treatment.

Payment Agreement: I, the undersigned, understand that I am responsible for all charges for treatment received regardless of insurance coverage. I understand that the Provider cannot accept responsibility for collecting any insurance claim or negotiating any settlement on a disputed claim. Provider reserves the right to decline further services to the patient for non-payment. Patient accounts are due at the time treatment is given unless other arrangements are made in advance. A charge of \$27.50 will be charged on all RETURNED CHECKS.

I, the undersigned, assign benefits payable for physician services to the physician or organization furnishing the services and authorize the physician group/organization to submit a claim to my health insurance carrier on my behalf.

Signature of Patient (or parent, if a minor) _____ Date _____



Permission to Perform Laboratory Testing

I understand I am fully responsible for any medical services not covered by my health insurance. I also acknowledge that the insurance information I have provided to the medical staff is full and complete to the best of my knowledge and I have provided secondary insurance information, if available. I understand it is my responsibility to know the coverage and limitations of my own insurance.

Signature _____ Date _____

Markel Insurance Company Participants

Medical procedures or laboratory testing is subject to a \$75 deductible each academic year (i.e., patient is responsible for the first \$75). I also understand benefits for preventative health care services, routine care, care for dietary control or treatment for pre-existing conditions (as defined in my *Student Medical Plan* booklet) are not offered.

I also acknowledge that I have been informed by Florida Tech Health Center staff that all testing for pregnancy or sexually transmitted diseases (STD) will not be covered by my student health insurance unless the testing returns positive results. I have also been informed that the Brevard County Health Department is available for STD testing with income-based fees. The location nearest the Florida Tech campus is 2275 S. Babcock St., Melbourne, FL, (321) 690-6486.

Signature _____ Date _____

Your Markel Student Insurance representative is Sharon Tyner (321) 432-5653.
We encourage you to consult your *Student Medical Plan* for further information regarding coverage and exclusions.
This booklet is available from the Student Health Center or Campus Services.



Name _____ Birth Date _____

List of Current Medications

Allergies to Medications _____

List previous surgeries/hospitalizations _____

Have you had a history of any of the following:

- Headaches
- Seizures
- Anemia
- Tuberculosis
- Skin Problems
- Sickle Cell Disease
- Heart Problems
- Liver Disease
- Urinary Problems
- STDs
- Anorexia
- Depression
- Eye Problems
- Blood Clots
- Diabetes
- Stomach/Bowel Problems
- High Blood Pressure
- Asthma/Lung Problems
- Cancer
- Gall Bladder Disease
- Allergies
- Blood Disease
- Bulimia
- Anxiety

Additional concerns _____

Have you ever been treated for mental illness or emotional problems? Yes No

Do you use Tobacco? Yes No Alcohol? Yes No Drugs? Yes No

Has anyone hit you or struck you in the last 18 months? Yes No

Are there any diseases that run in your family? Yes No If yes, please list _____

Signature _____ Date _____



Consent to the Use and Disclosure of Health Information for Treatment, Payment or Health Operations

I, _____ (patient name), understand that as part of my health care, this practice originated and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication amount the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations, and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to use or disclosure of my health information _____

I fully understand and accept decline the terms of this consent.

Signature of patient or legal representative _____ Date _____



I request the following alternatives or limitations relating to communications directed to me by my health care provider or employee of OMNI HEALTH CARE.

Do we have your permission to call you at Home? Yes No

If yes, may we leave the following information on your home answering machine or voice mail?

Appointment Information Yes No

Billing Information Yes No

Medical Information Yes No

May we call you at work? Yes No

If yes, may we leave the following information on your work answering machine or voice mail?

Appointment Information Yes No

Billing Information Yes No

Medical Information Yes No

I give my permission to share the following information with the person(s) named below:

Name _____ Relationship _____

Appointment: Yes No Billing: Yes No Medical: Yes No

Name _____ Relationship _____

Appointment: Yes No Billing: Yes No Medical: Yes No

Name _____ Relationship _____

Appointment: Yes No Billing: Yes No Medical: Yes No

Name _____ Relationship _____

Appointment: Yes No Billing: Yes No Medical: Yes No

Patient Signature _____ Date _____

Witness _____ Date _____

